DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 0 5

2. STATE: Wisconsin

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT 01

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 1,300K
b. FFY 2002 $ 5,100K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
i, ii, iii, iv, 6.3, 11, 14, 15, 33.1, 33.2, 33.3, 33.4, 33.7, 50, 51, 52 .....
53 .....
33.5, 33.6, 33.6a .....

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same
New
→ Removed — from current plan pages (33.5, 33.6, 33.6a

10. SUBJECT OF AMENDMENT:
Hospital inpatient rate updates

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED: Robert H Blanc

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Peggy B Handrich

13. TYPED NAME:
Peggy B. Handrich

14. TITLE:
Administrator, Division of Health Care Financing

15. DATE SUBMITTED:
September

16. RETURN TO:
Peggy B. Handrich
Administrator
Division of Health Care Financing
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
9-28-01

18. DATE APPROVED:
5/10/02

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
Luna Ann Mercado

21. TYPED NAME:
Cheryl A. Harris

22. TITLE:
Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
SEP 28 2001
DMCH - MI/MN/WI

FORM HCFA-179 (07-92)

Instructions on Back

DIVISION OF MEDICAID AND INSURANCE OVERSIGHT
CENTERS FOR MEDICARE AND MEDICAID SERVICES
WAIVER/STATE PLAN REVIEW AND RECOMMENDATIONS

State	Submittal No.	Date Received	Description (Title, Subject, etc.)
WI	01-005	09/28/01	4.19AHospital inpatient rate updates

Synopsis

Received in DMCH
09/28/01 for action by 10/13/01
(date) (25 days)

Submitted to MI/MN/WI Operations Branch
on 10/02/01 action by 10/13/01
(date) (25 days for reim/25 for other)

REVIEWED BY

MI/MN/WI Operations Branch

Assigned to Carson 01/02/01
(Name) (Date)

Recommendation _____
(approval or disapproval)

Remarks Jan Cmso'

5/2/02
(signed) (date)

AIC

Assigned to Perkins 10/02/01
(Name) (Date)

Recommendation _____
(approval or disapproval)

Remarks _____

_____
(signed) (date)

APPROVAL

Assigned to _____ _____
(Name) (date)

Recommendation _____
(approved or disapproved)

Remarks _____

_____
(signed) (date)

Approved by: Date 5/6/02

Pamela Chun, acting Branch Manager
MI/MN/WI Operations Branch Manager
MI/MN/WI Operations Branch
Division of Medicaid & Children's Health

Acting Dina Ann Mercado 5/10/02
Associate Regional Administrator
Division of Medicaid & Children's Health

Note:This completed form should be filed with Program Unit copy of HCFA-179. (Rev.12/99)
cc:MHG

State Plan Amendment Analysis

State WI

Transmittal # 01-005

Preprint No (Yes or No)

Attachments 4.19A I, ii, iii, iv, 6.3, 11, 14, 15, 33.1, 33.2, 33.3, 33.4, 33.7, 50, 51, 52, 53 New; 33.5, 33.6, 33.6a Removed

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Provision of Current State Plan ______________________

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Proposed Change: ______________________

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Fiscal Impact; ______________________

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Reason for Amendment: ______________________

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Signature ______________________ **Date** ______________________

Wisconsin Medicaid Program
Inpatient Hospital State Plan

Method and Standards For Determining Payment Rates
With Amendments Effective July 1, 2001

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5140.3 Weights Calculated.

The updated version of the Medicare grouper described in section 5130 above is applied to the historical claims from the period described in subsection 5140.1 above. Each claim is classified to and assigned its appropriate diagnosis related grouping (DRG) by the grouper.

The cost of each inpatient hospital claim is calculated. This is a hospital-specific claim cost that requires correlating the services charged on the claim to related cost centers of the hospital's cost report. For each claim, accommodation charges for the hospital stay are multiplied by the cost-to-charge ratios of accomodation cost centers in the respective hospital's cost report. The result is the cost of accommodations for the hospital stay. Ancillary service charges are multiplied by cost-to-charge ratios of ancillary cost centers in the respective hospital's cost report providing a cost for ancillary services. The resulting accommodation costs and ancillary service costs of each claim is summed resulting in the total cost of the inpatient stay.

The cost of each inpatient stay is further standardized (or adjusted) for area wage differentials and reduced for the cost attributed to capital costs, medical education costs and outlier costs.

Each claim's cost is inflated by an inflation multiplier to the current rate year. The inflation multiplier is derived from indices in the publication, "Health Care Cost Review", that is published quarterly by the Standard & Poor's DRI division of The McGraw-Hill Companies. (As of the second quarter of 2001, the "Health Care Cost Review" is published quarterly by DRI•WEFA, Inc., a Global Insight Company.) Specifically used are the total market basket indices as listed by calendar quarter in the tables for HCFA's hospital prospective reimbursement. In the publication's second quarter 2000 edition, this table is entitled "HCFA Hospital Reimbursement Market Based (PPS) – Historical Data" for historical quarters and, for forecasted future quarters, the table is entitled "HCFA Hospital Prospective Reimbursement Market Basket (PPS) – Quarterly Forecasts". (Note that HCFA may be changed to CMS in future publications.)

5240 Disproportionate Share Adjustment Percentage

5241 General.

Extra payments are provided to hospitals that provide a disproportionate share of services to Medicaid and low-income patients. A hospital may qualify for a disproportionate share adjustment if the hospital's Medicaid utilization rate is at least 1% and if either (1) the hospital's *Medicaid utilization rate* is at least one standard deviation above the mean Medicaid utilization rate for hospitals in the State, or (2) has a *low-income utilization rate* of more than 25%.

5242 Obstetrician Requirement.

In order for a qualifying hospital to receive its adjustment, it must have at least 2 obstetricians who have staff privileges and who have agreed to provide obstetrical care to WMAP recipients. Hospitals may substitute any physician with staff privileges to perform obstetrical care and who has agreed to provide care to WMAP recipients. If a hospital serves patients predominantly under age 18, or if the hospital did not offer non-emergency obstetrical care as of December 21, 1987, it need not comply with this obstetrical requirement in order to receive the adjustment.

5243 Medicaid Utilization Method.

A hospital with high Medicaid utilization may qualify for a disproportionate share hospital (DSH) adjustment. The DSH adjustment under this "Medicaid utilization method" is provided to hospitals in the Department's annual DRG rate update. A hospital's DSH adjustment is incorporated into the hospital's specific DRG base rate and ultimately into the payment a hospital receives for each Medicaid recipient's stay

Statewide Amounts Calculated: The Department annually calculates a "Medicaid inpatient utilization rate" for each hospital in the state that receives Medicaid payments. This is M in the following formula. From the compilation of the individual hospital utilization rates, the statewide mean average and standard deviation from the mean are calculated. The mean rate plus the amount of one standard deviation is S in the following formula.

Qualifying Hospital Under Medicaid Utilization Method: A hospital qualifies for a DSH adjustment if its Medicaid inpatient utilization rate (M) is equal to or greater than the mean-plus-one-standard-deviation (S) and is at least 1%.

Hospital Specific Adjustment Calculated: A "DSH adjustment percentage" is calculated according to the following formula for a hospital that qualifies under the Medicaid utilization method. See appendix section 27100 for amounts for current rate year.

[(M minus S) x F] + 3% where M = Hospital's Medicaid inpatient utilization rate
S = Statewide mean-plus-one-standard-deviation
F = Proportional increase factor

Adjustment for Certain IMDs. The above 3% factor is increased to 11% for any hospital institution for mental disease (IMD) which qualifies for a disproportionate share hospital adjustment and has an average length of stay that exceeds 60 days for Wisconsin Medicaid recipients. Any days of a Medicaid recipient's stay that are covered in whole or part by Medicare are excluded from the calculation of the average length of stay. The average length of stay is based on the rate year that ended in the calendar year preceding the calendar year in which the current rate year begins. For example, for rates effective July 1, 1996, the base will be the rate year July 1, 1994 to June 30, 1995.

Medicaid Inpatient Utilization Rate. For purposes of the above calculation, the term "Medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for Medicaid, and the denominator of which is the total number of the hospital's inpatient days.

5260 Rural Hospital Adjustment Percentage

5261 Qualifying Criteria.

A hospital may qualify for a rural hospital adjustment if it meets the following conditions. Administrative adjustments regarding qualifying for the rural hospital adjustment and the adjustment percentage are described in section 11900, items K, L and M. Critical access hospitals under section 5900 are not eligible to receive an adjustment under this section.

1. The hospital is located in Wisconsin, is not located in a HCFA defined metropolitan statistical area (MSA), and has the WMP's Wisconsin rural area wage index used in calculation of its hospital-specific DRG base rate.
2. As of January 1, 1991, the hospital was classified in a rural wage area by Medicare.
3. The hospital is not classified as a Rural Referral Center by Medicare.
4. The hospital did not exceed the median amount for urban hospitals in Wisconsin for each of the following operating statistics for the statistical years described below: (a) total discharges excluding newborns, (b) the Medicare case-mix index, and (c) the Wisconsin Medicaid case-mix index.
5. For rate years beginning on and after July 1, 1998, the combined Medicare and Medicaid utilization rate of the hospital is determined to be equal to or greater than 50.0%. For rate years beginning prior to July 1, 1998, the combined Medicare and Medicaid utilization rate has been equal to or greater than 55.0%.

For criteria item 1 above. The reclassification to an urban wage area, of a hospital which is located in a rural wage area, shall be rescinded by the Department if the urban wage area index to be applied to the hospital is lesser than the rural hospital adjustment. This allows the hospital to receive the urban wage adjustment or the rural hospital adjustment, whichever is greater. (Reference section 5226.)

For criteria item 4 above. The statistical year for total discharges excluding newborns will be the fiscal year of the hospital. The statistical year for the Wisconsin Medicaid case-mix index will be the state fiscal year. The statistical year for the Medicare case-mix index will be the federal fiscal year. The fiscal year to be used is that fiscal year which ended in the second calendar year preceding the annual July 1 rate update. (For example, for July 1, 1996 rate updates, the statistical years will be fiscal years that ended in 1994.) Urban hospital means any hospital located in Wisconsin which is located in a HCFA defined metropolitan statistical area (MSA) or which has a WMAP urban area wage index used in calculation of its hospital-specific DRG base rate.

For criteria item 5 above. The combined Medicare and Medicaid utilization rate is determined by dividing the total Medicare and Medicaid inpatient days by the total inpatient days. Long-term care days from hospital swing-beds shall not be included as inpatient days in this calculation. The inpatient days will be from the individual hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may at its option use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. If the audited cost report which is used is more than three years old, the hospital may request an administrative adjustment under §11900, item B, to have its rural adjustment based on a more current audited cost report. For the base cost reports to be used for hospitals combining operations, see section 5860.

5262 Adjustment Percentage.

The amount of the rural hospital adjustment is based on a qualifying hospital's Medicaid utilization rate. The Medicaid utilization rate is determined by dividing the total Medicaid inpatient days by the total inpatient days from the individual hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may at its option use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. Long-term care days from hospital swing-beds shall not be included as inpatient days in the denominator of this calculation.

The resulting Medicaid utilization rate is used to determine the adjustment percentage for the hospital-specific DRG base rate according to the table in appendix section 27300. The rural hospital adjustment percentage is that percentage corresponding to the range of utilization percentages in which the individual hospital's Medicaid utilization rate falls.

NOTE: To clarify for the federal Center for Medicare and Medicaid Services (CMS), the adjustment described in the above section 5260, specifically subsections 5261 and 5262, is NOT a disproporitonate share hospital (DSH) adjustment under Section 1923 of the Social Security Act.

5300 OUTLIER PAYMENTS UNDER DRG PAYMENT SYSTEM

5310 General

An outlier payment to the hospital provides a measure of relief from the financial burden presented by extremely high cost cases. It is an amount paid on an individual stay in addition to the DRG payment.

Cost based outlier adjustments and length-of-stay based outlier adjustments are provided. Each is described in detail below. If a hospital's claim qualifies under both the cost outlier and the length of stay outlier methods, then the Department shall pay under the method which gives the greater amount to the hospital.

The Department may evaluate the medical necessity of services provided and appropriateness of length of stay for all outlier cases prior to the issuance of outlier payments or, if payment has been made, recoup the same.

5320 Cost Outliers

5321 Qualifying Criteria for a Cost Outlier Payment.

For a hospital's claim to qualify for cost outlier payment, the following criteria apply:

1. The charges for a given case must be usual and customary.
2. The services provided must be medically necessary and the level of care appropriate to the medical needs of the patient.
3. The claim's cost, that is, charges-adjusted-to-cost, must exceed the DRG payment by the amount of the trimpoint applicable to the hospital. The applicable trimpoint will depend on the type and size of the hospital as follows for discharges on and after July 1, 1992.

	----- Trimpoint Amount -----	
Type of Hospital / Bed Size	Less than 100 Beds	100 Beds or Greater
General Medical & Surgical Hospitals	$ 5,235	$ 31,410
Hospital Institutions for Mental Disease (IMDs)	$ 5,460	$ 31,633

4. Hospital stays for which payment is not provided under the DRG payment system do not qualify for outlier payment consideration. This includes, but is not necessarily limited to, cases treated at rehabilitation hospitals and State-operated IMDs exempt from DRGs, cases treated at hospitals reimbursed on a percent-of-charges basis, and cases for services exempted from DRG payment system under section 7000. Claims for chronic, stable ventilator-dependant hospital patients shall be reimbursed under the ventilator rate and, therefore, are not eligible for a cost outlier payment.

5322 Charges Adjusted-To-Cost.

For Wisconsin Hospitals. For a hospital located in Wisconsin, claim charges are adjusted to costs using the hospital's specific cost-to-charges ratio for WMAP inpatient services. The cost-to-charges ratio to be used will be from a hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update except the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. For cost reports to be used for combining hospitals, see §5860.

For hospitals for which the Department does not have an audited cost report, the cost-to-charge ratio from the most recent unaudited cost report available to the Department will be used. This unaudited cost-to-charge ratio will be used until the Department gets an audited cost report.

SECTION 8100
SUPPLEMENTAL DISPROPORITONATE SHARE HOSPITAL PAYMENTS FOR ESSENTIAL ACCESS CITY HOSPITALS (EACH)

The special payments described in this section 8100, specifically subsections 8110 through 8130, are disproportionate share hospital payments provided in accord with the federal Social Security Act, Section 1902(a)(13)(A)(iv) and Section 1923.

Supplemental disproportionate share hospital payments are provided for any hospital located in Wisconsin which meets the following criteria for an "essential access city hospital" (EACH).

8110 Qualifying Criteria for EACH Disproportionate Share Hospital Supplement

A hospital qualifies for an EACH supplement in the current rate year if in the current rate year the hospital qualifies for a disproportionate share hospital adjustment under section 5240 and if the hospital met the following criteria during the year July 1, 1995 through June 30, 1996.

1) The hospital is located in the inner city of a city of the first class in Wisconsin as identified by the following U.S. Postal Service Zip Code areas. As of July 1, 1997, the following contiguous U.S. Postal Service Zip Code areas identify one inner city area covered by this supplement: 53202, 53203, 53205, 53206, 53208, 53209, 53210, 53212, 53216 and 53233.
2) At least 30% of the hospital's Medicaid recipient inpatient stays are for Medicaid recipients who reside in an inner city zip code area listed above.
3) More than 30% of the hospital's total inpatient days are Medicaid covered inpatient days.
   (a) including Medicaid HMO covered days and Medicaid covered stays on which Medicaid made no payment due to the stay being covered by some other payer such as hospitalization insurance
   (b) but not including days of Medicaid recipients' stays that are covered in full or part by Medicare.
4) The hospital is an acute care general hospital providing medical and surgical, neonatal ICU, emergency and obstetrical services.

8115 Determination of EACH Disproportionate Share Hospital Supplement

The EACH supplement is paid in a prospectively established monthly amount based on the past Medicaid utilization of the hospital. The amount of a qualifying hospital's supplement is recalculated annually for the upcoming rate year. The total statewide funding for the EACH supplement is limited to the amount that is listed in Appendix Section 27100. This amount is distributed proportionately among qualifying hospitals based on Medicaid inpatient days of the qualifying hospitals.

A qualifying hospital's EACH supplement will be determined as follows:

$$\text{Hospital's Annual EACH Supplement} = \frac{\text{Medicaid days for hospital}}{\text{Sum of Medicaid days of qualifying hospitals}} \times \text{Statewide Annual Funding Listed in Appendix 27100}$$

The monthly amount is the above annual amount divided by 12 months.

Medicaid days are a hospital's total covered inpatient days for Medicaid recipients for the calendar year prior to the rate year for which the EACH supplement is being calculated. The days include Medicaid HMO covered days and Medicaid covered days on which Medicaid made no payment due to the days being covered by some other payer such as hospitalization insurance but do not include days of Medicaid recipient stays that are covered in full or part by Medicare.

8130 Sanction on Not Continuing To Meet Qualifying Criteria

A hospital receiving an EACH supplement is expected to maintain its effort to serve MA recipients including recipients and residents in the inner city area. If the Department finds a hospital fails to meet the above qualifying criteria above for any three month period, then payment of the supplement will be discontinued for the hospital and payments made for the three month period will be recovered. If the hospital shows it subsequently meets the criteria for any three-month period, then the supplemental payment will be reinstated at, and retroactive payment made since, the beginning of the three-month period in which the criteria were again met. If any qualifying hospital is sanctioned in a rate year, the monthly supplement of other qualify hospitals will not be recalculated to redistribute the total annual funding for the EACH supplement.

SECTION 8200
GENERAL ASSISTANCE DISPROPORTIONATE SHARE HOSPITAL ALLOWANCE

8205 Introduction.

The special payments described in this section 8200, specifically subsections 8205 through 8260, are disproportionate share hospital payments provided in accord with the federal Social Security Act, Section 1902(a)(13)(A)(iv) and Section 1923.

Disproportionate share hospital (DSH) payment adjustments are provided to hospitals that provide a significant amount of services to low-income persons covered by a county administered general assistance (GA) program and Wisconsin Medicaid program (WMP) recipients. These supplemental payments are termed the "general assistance disproportionate share hospital payments" or "GA-DSH". Low-income persons may be eligible for county administered general assistance under financial income criteria similar to or more restrictive than eligibility requirements for the Wisconsin Medicaid program. A person who is eligible for Medicaid is not eligible for county general assistance. The identifying of services that a hospital provides to persons eligible for a county general assistance program is a reliable method for identifying the quantity of services that a hospital provides low-income persons other than Medicaid recipients.

8210 Qualifying Criteria.

A hospital is a disproportionate share (DSH) hospital and qualifies for general assistance disproportionate share hospital payments (GA-DSH) if the hospital meets either criteria 1) or 2) below and meets all the criteria of 3) below.

1) At least 13.0% of the hospital's operating expense is attributable to services provided persons eligible for a county GA program and to persons eligible under the WMP of which at least 2.0% is attributable to services provided persons eligible for a county GA program.

2) At least $8,000,000 of the hospital's annual operating expense is attributable to services provided persons eligible for a county GA program and to persons eligible under the WMP which includes at least $4,000,000 attributable to services provided persons eligible for a county GA program

3) In addition to either 1) or 2) above, the hospital must meet all of the following criteria:
   a) The hospital meets the obstetrician requirements of §5242.
   b) The hospital has a Medicaid inpatient utilization rate of at least 1% determined under §5243.
   c) The hospital or its parent corporation has a contract with the county government to serve low-income persons covered by the county's general assistance program.

For a hospital to qualify as a DSH hospital under this §8200, the hospital is not required to meet the qualifying criteria for DSH under §5240. In contrast, a hospital that qualifies as a DSH hospital under this §8200 can qualify for the DSH adjustment under §5240 if, and only if, the hospital meets the qualifying criteria of §5240.

(Continued on next page, page 33.3)

8215 Calculation of Qualifying Percentages and Amounts for Individual Hospital

The amounts and percentages of operating expenses attributable to services provided to low-income GA persons and WMP recipients are determined as described in following table.

ITEM	DESCRIPTION
Total MA FFS Charges	Total fee-for-service charges by the hospital to the WMP for inpatient and outpatient services provided WMP recipients in the calendar year prior to the July 1 rate year. For example, for rate year beginning July 1, 1997, the calendar year of 1996 is used.
Total MA HMO Charges	For inpatient and outpatient services provided WMP recipients covered by Medicaid HMO or managed care contractors, total charges by the hospital in the calendar year prior to the July 1 rate year. If charges not available, zero is used
Total GA Charges	Total charges by the hospital for inpatient and outpatient services provided persons eligible for a county GA program in the calendar year prior to the July 1 rate year.
Ratio, Cost-to-Charges	The ratio of the hospital's overall costs to overall charges for hospital patient services, not to exceed 1.00, as determined from the hospital's most recent audited cost report on file with the WMP as of the effective date of the annual rate update.
Total Hospital Expenses	Total hospital patient care expenses from the hospital's most recent audited cost report on file with the WMP as of the effective date of the annual rate update.
Calculated MA & GA Expense	Total expenses attributed to inpatient and outpatient hospital services provided to WMP recipients and provided to persons eligible for a county GA program, calculated as: *("Total MA FFS Charges" + "Total MA HMO Charges" + "Total GA Charges") X "Ratio, Cost-to-Charges"* This amount is compared to the $8,000,000 qualifying criteria in §8210, item 2), prior page.
Percent, MA & GA Expense	Percent of hospital's operating expenses attributable to services provided persons eligible for a county GA program and the WMP, calculated as: *"Calculated MA & GA Expense"* *divided by* *"Total Hospital Expenses"* This percent is compared to the 13.0% qualifying criteria in §8210, item 1), prior page.
Calculated GA Expense	Total expenses attributed to inpatient and outpatient hospital services provided persons eligible for a county GA program, calculated as: *"Total GA Charges" X "Ratio, Cost-to-Charges"* This amount is compared to the $4,000,000 qualifying criteria in §8210, item 2), prior page.
Percent, GA Expense	Percent of hospital's operating expenses attributable to services provided persons eligible for the county GA program, calculated as: *"Calculated GA Expense"* *divided by* *"Total Hospital Expenses"* This percent is compared to the 2.0% qualifying criteria in §8210, item 1), prior page.

8250 Calculation of Qualifying Hospital's Monthly GA-DSH Allowance

A monthly payment amount is calculated as described below for each qualifying hospital. Total payments for the rate year to all qualifying hospitals is not to exceed the maximum available funding for the GA-DSH allowance. This maximum is specified in appendix section 27100. For the individual qualifying hospital, total payments for the allowance are not to exceed the individual hospital's expenses attributable to GA services.

ITEM	DESCRIPTION
Sum of Calculated GA Expense for All Hospitals	Total of the "Calculated GA Expense" of all hospitals in the state that qualify for the GA-DSH supplement. This is the sum of the GA expense amounts calculated under §8215 for each of the qualifying hospitals.
Maximum Annual Funding	The maximum available funding for general assistance disproportionate share hospital payments in a rate year. The annual maximum amount for a rate year is specified in Appendix Section 27100 herein.
Ratio, Maximum Funding -to- Sum of Expenses	The percentage of the statewide GA expenses of qualifying hospitals that can be funded with the available funding, calculated as follows, limited to 100% of expenses *"Maximum Annual Funding"* *divided by* *"Sum of Calculated GA Expense for All Hospitals"*
One Hospital's Monthly GA-DSH Allowance	A hospital's monthly GA-DSH allowance, based on the hospitals calculated GA expense under §8215, calculated as: *("Calculated GA Expense" X "Ratio, Maximum Funding-to-Sum of Expenses")* *divided by* *12 Months*

8260 Combining Historical Financial Statistics for Recent Hospital Combinings

Hospital combinings result from hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant.

When hospitals combine into one hospital, the required years of historical data may not be available for the combined operation for one or more rate years after the combining occurs. Whenever a required year of data is available for a full year of the combined hospital operation, then that year of data is used. However, if a full year is not available for the combined operation, then data of the individual hospitals for the required years is combined or added together for the calculations under §8210 through §8250.

SECTION 9100
LIMIT ON AMOUNT OF DISPROPORTIONATE SHARE PAYMENT TO A HOSPITAL

A hospital's disproportionate share payments during its fiscal year may not exceed the sum of the payment shortfall for MA recipient services and the unrecovered cost of uninsured patients. The amount of disproportionate share payments which exceed this limit shall be determined retrospectively after a hospital completes its fiscal year. (Statutory Background. Section 1923(g) of the federal Social Security Act.)

Payment Shortfall for MA Recipient Services. The payment shortfall for MA recipient services is the amount by which the costs of inpatient and outpatient services provided MA recipients exceed the payments made to the hospital for those service excluding disproportionate share hospital payments. Disproportionate share hospital payments are payments provided a hospital under the State of Wisconsin Medicaid State Plan according to the provisions of the Social Security Act, Section 1902(a)(13)(A)(iv) and Section 1923. If payments exceed costs, the financial gain from MA will not be applied against the unrecovered cost of uninsured patients.

The cost will be established by multiplying charges for inpatient and outpatient services by a ratio of costs to charges for patient care services. The ratio will be determined from the most current audited Medicaid cost report on file with the Department. Services provided MA recipients covered by an HMO under the WMAP will be included.
For outpatient MA services, interim outpatient payments limited to charges for the hospital's fiscal year will be used. For inpatient MA services, payments limited to charges will be also used. Payments limited to charges will be the lesser of (a) charges made by the hospital during its fiscal year for MA services, or (b) overall payments from all sources (as defined in §9000) for MA services during its fiscal year, excluding disproportionate share payments. This charge limit will be applied separately to payments for inpatient services and payments for outpatient services for the period of the hospital's fiscal year.

Unrecovered Cost of Uninsured Patients. The unrecovered cost of uninsured patients is the amount by which the costs of inpatient and outpatient services provided to uninsured patients exceed any cash payments made by them. *However, as provided in the Social Security Act, Section 1923(g)(1)(A), "For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government with a State shall not be considered to be a source of third party payment."*

If payments exceed costs, the financial gain will not be applied against the MA payment shortfall. An uninsured patient is an individual who has no health insurance or source of third party payment for the services provided by the hospital. The cost will be established by multiplying charges for inpatient and outpatient services by a ratio of costs to charges for patient care services. The ratio will be determined from the most current audited Medicaid cost report on file with the Department.

Recovery of Excess Disproportionate Share Payments. If total disproportionate share payments to the hospital for services provided during its fiscal year exceed the sum of the payment shortfall for MA recipient services and the unrecovered cost of uninsured patients, then the excess disproportionate share payments will be recovered from the hospital.

Administrative Adjustments. A hospital may request an administrative adjustment under section 11900, item N, if an amount is to be recovered. The hospital or the Department may initiate an administrative adjustment under item O after completion of the outpatient final settlement for the hospital's fiscal year.

Effective Date. This limitation applies only to hospitals owned or operated by a State or by a unit of local government beginning July 1, 1994. With respect to hospitals that are not owned or operated by a State or unit of local government, this limitation applies beginning July 1, 1995 unless the federal Department of Health and Human Services exempts such hospitals or modifies the limitation for them.

For hospitals with fiscal years in progress (not beginning) on July 1, 1994 (or July 1, 1995 if applicable), the MA shortfall and the unrecovered cost of uninsured for the fiscal year will be prorated between the period before July 1 and the period on and after July 1 based on the proportion of disproportionate share payments applicable to each period.

APPENDIX SECTION 27000
AREA WAGE INDICES
Effective July 1, 2001

The following wage area indices are based on hospital hours and salaries for hospital fiscal years that began in federal fiscal year October 1996 through September 1997 and that were used to create the wage indices used in the Medicare hospital prospective payment system (PPS).

WAGE AREAS FOR WISCONSIN HOSPITALS	For Original Remaining Hospitals in Area	For Hospitals Reclassified to Area
Appleton/Neenah/Oshkosh	.9582	None
Eau Claire	.9282	None
Green Bay	.9734	None
Janesville/Beloit	1.0099	None
Kenosha	1.0332	None
La Crosse	.9744	None
Madison	1.0754	1.0754
Milwaukee County	1.0502	None
Ozaukee-Washington-Waukesha Counties	.9971	.9971
Racine	.9665	None
Sheboygan *See Note A*	.8829 *(Use .9217)*	None
Superior, WI / Duluth, MN	1.0865	None
Wausau	.9969	.9969
Rural Wisconsin	.9217	None

Note A – Section 5224, page 9, requires that " the index applied to any hospital located in Wisconsin shall not be lesser than the rural Wisconsin index." The Sheboygan wage index is lesser than the Rural Wisconsin wage index. Therefore, a hospital in the Sheboygan wage area will receive the Rural Wisconsin wage index of .9217.

WAGE AREAS FOR BORDER STATUS HOSPITALS	For Original Remaining Hospitals in Area	For Hospitals Reclassified to Area
Twin Cities, Minnesota (St. Paul, Minneapolis, Coon Rapids, Edina, Lake City, Robinsdale, Stillwater, Chisago City, Hasting)	1.1725	None
Duluth, Minnesota	1.0865	None
Rochester, Minnesota	1.1906	None
Rockford, Illinois	.9319	None
Dubuque, Iowa	.9214	None
Chicago - Woodstock, Harvard, Illinois	1.1097	None
Iowa City, Iowa	1.0309	None
Rural Illinois	.8600	None
Rural Minnesota	.9625	None
Rural Michigan	.9845	None

APPENDIX 27200
INFLATION RATE MULTIPLIERS
FOR ADMINISTRATIVE ADJUSTMENTS
FOR RATES EFFECTIVE JULY 1, 2001 THROUGH JUNE 30, 2002

Inflation rates to be applied in calculating the following administrative adjustments of §11900:

Item B -- Capital and direct medical education payment based on cost report more than three years old

Item C -- Capital payment adjustment for major capitalized expenditures

Item D -- Adjustment for changes in medical education

Month Fiscal Year Ended	Inflation Multiplier
1995	
Jan-95	1.2259
Feb-95	1.2259
Mar-95	1.2259
Apr-95	1.2158
May-95	1.2158
Jun-95	1.2158
Jul-95	1.2080
Aug-95	1.2080
Sep-95	1.2080
Oct-95	1.2047
Nov-95	1.2047
Dec-95	1.2047
1996	
Jan-96	1.1949
Feb-96	1.1949
Mar-96	1.1949
Apr-96	1.1874
May-96	1.1874
Jun-96	1.1874
Jul-96	1.1800
Aug-96	1.1800
Sep-96	1.1800
Oct-96	1.1758
Nov-96	1.1758
Dec-96	1.1758
1997	
Jan-97	1.1696
Feb-97	1.1696
Mar-97	1.1696
Apr-97	1.1686
May-97	1.1686
Jun-97	1.1686
Jul-97	1.1584
Aug-97	1.1584
Sep-97	1.1584
Oct-97	1.1513
Nov-97	1.1513
Dec-97	1.1513

Month Fiscal Year Ended	Inflation Multiplier
1998	
Jan-98	1.1434
Feb-98	1.1434
Mar-98	1.1434
Apr-98	1.1316
May-98	1.1316
Jun-98	1.1316
Jul-98	1.1230
Aug-98	1.1230
Sep-98	1.1230
Oct-98	1.1182
Nov-98	1.1182
Dec-98	1.1182
1999	
Jan-99	1.1145
Feb-99	1.1145
Mar-99	1.1145
Apr-99	1.1070
May-99	1.1070
Jun-99	1.1070
Jul-99	1.0978
Aug-99	1.0978
Sep-99	1.0978
Oct-99	1.0879
Nov-99	1.0879
Dec-99	1.0879
2000	
Jan-00	1.0773
Feb-00	1.0773
Mar-00	1.0773
Apr-00	1.0660
May-00	1.0660
Jun-00	1.0660
Jul-00	1.0550
Aug-00	1.0550
Sep-00	1.0550
Oct-00	1.0466
Nov-00	1.0466
Dec-00	1.0466

Month Fiscal Year Ended	Inflation Multiplier
2001	
Jan-2001	1.0384
Feb-2001	1.0384
Mar-2001	1.0384
Apr-2001	1.0304
May-2001	1.0304
Jun-2001	1.0304
Jul-2001	1.0216
Aug-2001	1.0216
Sep-2001	1.0216
Oct-2001	1.0138
Nov-2001	1.0138
Dec-2001	1.0138
2002	
Jan-2002	1.0068
Feb-2002	1.0068
Mar-2002	1.0068
Apr-2002	1.0000
May-2002	1.0000
Jun-2002	1.0000
Jul-2002	0.9918
Aug-2002	0.9918
Sep-2002	0.9918
Oct-2002	0.9844
Nov-2002	0.9844
Dec-2002	0.9844
2003	
Jan-2003	0.9764
Feb-2003	0.9764
Mar-2003	0.9764

APPENDIX SECTION 27300

RURAL HOSPITAL ADJUSTMENT PERCENTAGES PURSUANT TO SECTION 5260

The following table lists the the rural hospital adjustment percentages that are applied under section 5260. The rural hospital adjustment percentage is that percentage corresponding to the range of utilization percentages in which the individual hospital's Medicaid utilization rate falls. For example, a Medicaid utilization rate of 7.34% falls in the "5.0% through 9.99%" range that has a corresponding 11% rural hospital percentage. Similarly, a 11.23% utilization rate corresponds to a 17% rural hospital percentage.

EFFECTIVE ON and AFTER JULY 1, 2001

Medicaid Utilization Rate	Rural Hospital Adjustment Percentage
Up through 4.99%	5.00%
5.0% through 9.99%	11.00%
10.0% through 14.99%	17.00%
15.0% and greater	23.00%

EFFECTIVE JULY 1, 2000 THROUGH JUNE 30, 2001

Medicaid Utilization Rate	Rural Hospital Adjustment Percentage
Up through 4.99%	8.00%
5.0% through 9.99%	17.00%
10.0% through 14.99%	26.00%
15.0% and greater	35.00%